Municipal Health Benefit Fund

P.O. Box 188
North Little Rock, AR 72115
(501) 374-3484

DENTAL CLAIM FORM — THIS FORM MUST BE COMPLETED BY MEMBER/EMPLOYEE

NAME OF CITY OR ENTITY _____

MEMBER'S NAME _____

DATE OF BIRTH _____ SEX _____

STREET ADDRESS _____

CITY & STATE _____
ZIP CODE

Eligible Class (Please check applicable class)

- ☐ **Elected Official**
- ☐ **Member of** _____ **Board or Commission**
- ☐ **Volunteer Firefighter**
- ☐ **Auxiliary Policeman**
- ☐ **Retired Status**
- ☐ **Full Time Active Employee (Working at least 30 hours per week)**

I HEREBY PRESENT THIS CLAIM, and authorize any individual or organization to release information required for its acceptance.

1 CLAIM IS BEING MADE FOR:

☐ Self ☐ Unmarried child to age 19

☐ Wife/Husband ☐ Unmarried full time student age 19 and over, attending _____

2 PATIENT'S NAME | DATE OF BIRTH | SEX

3 IS CLAIM DUE TO AN ACCIDENT? ☐ Yes ☐ No | IF 'YES', WHERE DID ACCIDENT OCCUR? | DATE OF ACCIDENT

DESCRIBE ACCIDENT:

4 IS THIS CLAIM THE RESULT OF A WORK RELATED ILLNESS OR INJURY? ☐ Yes ☐ No **IF YES, PLEASE FILE WITH WORKERS' COMPENSATION CARRIER FIRST.**

5 IF MARRIED, IS YOUR WIFE/HUSBAND EMPLOYED? ☐ Yes ☐ No

NAME

EMPLOYER

ADDRESS

5a IF CLAIM IS FOR A DEPENDENT CHILD, IS THIS CHILD EMPLOYED? ☐ Yes ☐ No

EMPLOYER

ADDRESS

6 IS PATIENT ALSO COVERED FOR ANY **OTHER** INSURANCE BENEFITS AS LISTED BELOW, EITHER AS AN EMPLOYEE OR DEPENDENT? ☐ Yes ☐ No

If Yes, check box below which applies and complete 6a.

- ☐ Group health insurance of any kind including Blue Cross and Blue Shield
- ☐ Coverage of medical care expenses provided by an employer, a union welfare plan, any federal, state, provincial or other governmental program.
- ☐ Other arrangement of benefits for individuals of a group

6a GIVE NAME AND ADDRESS OF **OTHER** COMPANY OR ORGANIZATION PROVIDING INSURANCE:

NAME

ADDRESS

OTHER INSURANCE OR BLUE CROSS/BLUE SHIELD GROUP NO.(s)

8 MEMBER/EMPLOYEE'S SIGNATURE | SOC. SEC. NO. / / | DATE

EMPLOYER'S STATEMENT

EFFECTIVE DATE OF COVERAGE

MEMBER/EMPLOYEE

DEPT.

DATE

IS PATIENT'S COVERAGE CURRENTLY IN FORCE?
YES NO DATE TERMINATED

CITY OF

SIGNATURE OF EMPLOYER'S REPRESENTATIVE

MUNICIPAL HEALTH BENEFIT FUND DENTAL CLAIM FORM

(ATTENDING DENTIST'S STATEMENT)

1. PATIENT NAME

2. RELATIONSHIP TO EMPLOYEE SELF | SPOUSE | CHILD | OTHER

3. SEX M | F

4. PATIENT BIRTHDATE MO | DAY | YEAR

5. IF FULL TIME STUDENT SCHOOL CITY

6. EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST

7. EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.

8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS

CITY, STATE, ZIP

9. NAME OF GROUP DENTAL PROGRAM

10. EMPLOYER (COMPANY) NAME AND ADDRESS

11. GROUP NUMBER

12. LOCATION (LOCAL)

13. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME SOC. SEC. NO.

14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13

15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? DENTAL PLAN NAME UNION LOCAL GROUP NO. NAME AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

SIGNED (PATIENT, OR PARENT IF MINOR) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTISTS OF THE GROUP BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (MEMBER OR AUTHORIZED PERSON) DATE

16. DENTIST NAME

17. MAILING ADDRESS

CITY, STATE, ZIP

18. DENTIST SOC. SEC. OR T.I.N.

19. DENTIST LICENSE NO.

20. DENTIST PHONE NO.

21. FIRST VISIT DATE CURRENT SERIES

22. PLACE OF TREATMENT OFFICE | HOSP. | ECF | OTHER

23. RADIOGRAPHS OR MODELS ENCLOSED? NO | YES | HOW MANY?

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) 29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

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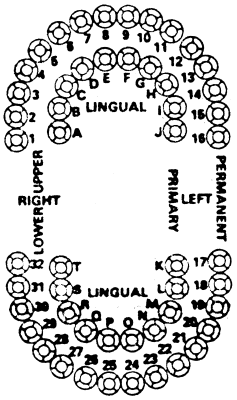

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INDICATE MISSING TEETH WITH AN 'X'

GIVE DATES OF EXTRACTION FOR MISSING TEETH:

EXAMINATION AND TREATMENT RECORD — LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO. DAY YR.	PROCEDURE NUMBER	FEE
				TOTAL FEE ACTUALLY CHARGED	

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE WILL BE OR HAVE BEEN PERFORMED.

DENTIST'S SIGNATURE _____ Date _____

Approved by the Council on Dental Care Programs of the American Dental Association July 1967